Jennifer M. Granholm, Governor
Janet Olszewski, Director

Fluoride Varnish Program
Varnish! Michigan Grant
2008-2009

REQUEST FOR PROPOSALS

Issued by:

Michigan Department of Community Health
Bureau of Family, Maternal and Child Health
Division of Child and Family Health
Oral Health Program

Phone: (517-373-3624)
Fax: (517-335-8697)

Notification of Intent to Apply Due: **April 25, 2008**
Proposals Due: **May 2, 2008**
Copies Required: **Signed Original plus 3 copies**
Award Notification: **May 30, 2008**

Instructions for Completing the Grant Application

This abbreviated Varnish! Michigan Grant Application was created specifically for public and nonprofit entities to initiate, expand or extend a dental screening and fluoride varnish program to as many as possible high risk infants and preschool children, ages 0-5, in the state of Michigan. Finding access to dental care for these children will be a main focus as well as oral health education to caregivers. Programs will be reimbursed from a generous donation from Delta Dental of Michigan. Emphasis will be targeted to the 0-2 age group children to encourage early prevention in the cessation of dental decay. Medical and dental professionals may apply. Physicians, physician assistants, nurse practitioners, RNs, dentists, dental hygienists and registered dental assistants under the supervision of a dentist are eligible to apply fluoride varnish. Emphasis will be in communities with non fluoridated drinking water, Health Professional Shortage Areas (HPSA), local public health facilities, and Federally Qualified Health Centers (FQHCs**). Providers will be expected to provide services at each infant/preschool site unless prior arrangements are made with the agency or you are a medical provider servicing the children in your clinic.**

Grant Proposal

Applicants may submit only one Abbreviated Application to initiate, expand or extend a Dental Screening and Fluoride Varnish Program to high risk infants and preschool children in the state of Michigan. The application can include Early Head Start, Head Start, Michigan Readiness, Early On, or other high risk infant and preschool children.

A priority will be for children, ages 0-2, where the program meets all the application's criteria. Two dental screenings and two to four applications of fluoride varnish are expected to be provided in a 12-month period starting October 1, 2008. **Reimbursement will be at $15 per application of fluoride varnish per child ($15 x 4). This could be a great opportunity for medical professionals to service this difficult to access age group.**

Funding also will be available for children, ages 3-5. Two dental screenings and two applications of fluoride varnish are expected to be provided in a 12-month period starting no later than October 1, 2008. **Reimbursement will be at $15 per application of fluoride varnish per child ($15 x 2).**

All terms, conditions and limitations specified in the Abbreviated Grant Application will be reviewed and scored according to relevant review criteria described in **Selection Criteria** on page 8.

Instructions for Grant Proposal Submission

Applicants should review all included materials and selection criteria.

Notification of Intent to Apply Due: **April 25, 2008**
Completed Applications Due: **May 2, 2008 by 5:00 p.m**

Applications should be typed or clearly printed and submitted to:

MDCH - FCH
Oral Health Program
Attn: Susan Deming, R.D.H., B.S.
Education and Fluoridation Coordinator
201 Townsend St.
Lansing, MI 48913

Phone: (517) 373-3624 Fax: (517) 335-8697 or 8294
E-Mail: demings@michigan.gov

Applicants are responsible for the timely receipt of their proposal. **PROPOSALS RECEIVED AFTER THIS DATE AND TIME WILL NOT BE CONSIDERED. E-MAIL OR FAXED RESPONSES WILL NOT BE ACCEPTED.**

BACKGROUND AND PURPOSE

The Michigan Department of Community Health (MDCH) Oral Health Program is offering grants to initiate new Dental Screening and Fluoride Varnish Programs or expand or extend a current Varnish! Michigan Program to the largest possible number of high risk infant and preschool children in the state of Michigan. Through this grant, you will be able to provide caries risk assessments, dental screenings and fluoride varnish to Michigan's youngest high risk children as well as provide oral health education to caregivers and find these children a "dental home". Medical professionals, as well as dental professionals, will be expected to establish a dental home for these children through contacts and referrals with dental care providers.

Collection of dental health data through the dental screenings will be used to determine the decay prevalence of high risk infant and preschool children and assist the MDCH to promote future dental health programs. The application of fluoride varnish on this very young population can significantly reduce dental disease in this group. National and international studies demonstrate a 40-75% reduction in dental caries with the application of fluoride varnish. Finding this group of children a "dental home" for future dental care needs and providing oral health education to parents and preschool staff will be a focus of the grant.

Funding for the grant is made possible through a generous contribution from Delta Dental Plans of Michigan. The grant awards are available for a 12-month period to begin October 1, 2008. Support letters and parental consents may be obtained before the program start date but the actual varnish applications cannot commence until October 1, 2008 and grant reimbursement will not be awarded until after October 1, 2008. It is suggested that for success of this program parental consents are obtained and oral health education to staff and parents is initiated prior to Oct 1, 2008.

The grants are designed as an incentive to initiate, expand, or extend the Varnish! Michigan Program to these high risk infant and preschool children with the expectation that, once established, the programs can be sustainable through the billing of services through Medicaid, other third party payers or community-based efforts.

ELIGIBLE APPLICANTS

- Public and nonprofit organizations such as health departments, FQHCs, dental clinics, dental or dental hygiene schools
- PA 161 dental hygiene service providers; May consider contracting through a medical or dental health care facility
- Pediatric care facilities that service high risk children
- Infant and preschool agencies for high risk children.

AVAILABILITY OF FUNDING

Awards are contingent upon availability of funds. The number of grants to be awarded will be determined by the number of proposals received and the amount of funds requested. Award amounts will be based on a $15.00 per application of fluoride varnish reimbursement schedule. (Please refer to the Funding Estimate Worksheet found later in this RFP. This completed Worksheet must be included with your final proposal.)

Awards will be made October 1, 2008. Applicants will be notified of award decisions by May 30, 2008.

After the dates to provide the dental screening/fluoride varnish program have been established with each infant and preschool group, and letters of support and commitment are obtained from each infant and preschool agency,

for the 12-month period of this program, funds are to be dispensed on a quarterly basis. Reimbursement will be contingent upon MDCH receiving data collected from each grantee. Prior to the third quarter of the funding cycle, balances will be readjusted (decreased or increased) based on program reports and projected needs.

Any funds received by the recipient of the award but not spent for this specific purpose must be returned to the Michigan Department of Community Health. In submitting the application, the applicant assures that funds will be used exclusively for the intended program with these groups. The MDCH will not assume any responsibility or liability for costs incurred by the recipient of the award prior to the signing of an agreement. Funds will be set-aside for an independent analysis, contracted at the discretion of MDCH to evaluate the relative merits of all programs funded.

CONTRACTOR RESPONSIBILITIES

The award recipient will be required to assume responsibility for all contractual activities offered in the proposal whether or not that recipient performs them. If any part of the program is to be provided by persons other than the recipient, responses to the RFP must include a list of these persons, including name, address, organization, credentials and services to be provided. The state will consider the selected award recipient to be the sole-point-of-contact with regard to program matters, including payment of any and all charges resulting from the award.

REIMBURSMENT MECHANISM

All award recipients must sign-up through the on-line vendor registration process to receive all State of Michigan payments in the form of Electronic Funds Transfers (direct deposits), as mandated by PA 533 of 2004. Vendor registration information is available through the Department of Management and Budget's web site: http://www.cpexpress.state.mi.us/

DISCLOSURE OF PROPOSAL CONTENTS

All information in an applicant's proposal is subject to disclosure under the provisions of Public Act No. 442 of 1976, known as the "Freedom of Information Act." This act also provides disclosure of contracts and attachments thereto.

ISSUING OFFICE

This Request for Proposals (RFP) is issued by the Michigan Department of Community Health's Oral Health Program, hereafter known as MDCH or the Department. The issuing office is the sole-point-of-contact for persons/organizations who are considering preparing responses to this RFP. The award will be made to the bidder(s) who most successfully meet the criteria of the RFP, up to the total amount of funds available within the funding level stipulated.

USE OF FUNDS

Funds available under this announcement for the Varnish! Michigan Grant should be primarily used for costs involved for the Dental Screening and Fluoride Varnish Program such as forms to be used, fluoride varnish, infection control supplies and personnel costs. Funds may not be used to supplant funds for existing programs.

Any funds received by the recipient of the award but not spent for the specific purpose must be returned to the Michigan Department of Community Health (MDCH). In submitting the application the applicant assures that funds will only be used for the intended program. The MDCH will not assume any responsibility or liability for costs incurred by the recipient of the award prior to the signing of an agreement. Funds will be set-aside at the discretion of MDCH for an independent analysis of program expenses, staffing and operating expenses of funded programs. Relative merits of all programs funded will be evaluated.

USE OF PRIVATE INSURANCE

Make reasonable efforts to collect 1st and 3rd party fees, where applicable, and report these as outlined by the Department's fiscal procedures. Any other recoveries of otherwise available fees resulting from failure to bill for eligible services will be excluded from reimbursable expenditures.
** Medicaid is in the process of a policy change to allow medical professionals to bill for fluoride varnish application. It is expected to become effective October 1, 2008.

QUESTION AND ANSWER PERIOD

A proposal conference will not be held. Questions may be submitted electronically until **April 25, 2008**. E-mail responses will be prepared and sent to all parties who have submitted a letter of intent. To expedite the answers, include your fax number and e-mail address with your letter of intent.

Letters of Intent must be received by April 25, 2008. Any correspondence regarding the grant will only be sent to those that have submitted Letters of Intent.

SPECIFICATIONS

All proposals must address or comply with the following specifications:

- Applicants must determine the number of high risk infant and preschool children that they could reasonably provide the Dental Screening and Fluoride Varnish Program to in a 12-month period. Subtract 20% for refused parent consents and absenteeism. Applicants must determine the number of fluoride applications they expect to provide in this 12 month period. **If you are a medical professional that plans on servicing children that are seen in your clinic please estimate the number of children you may see based on previous numbers of these age groups and pregnant women that will have 6 month and older children during the grant cycle. Please determine the number of fluoride applications you expect to deliver in this 12 month period.**

- **Applicants must provide a list of all infant and preschool sites they will be servicing or list the name of your clinic and how many children you will see. Please include the name of the site, the address and county of each site, and the number of children at each site, minus 20%. Indicate how many fluoride applications you expect to apply in this 12 month period. Please also indicate which type of infant and/or preschool/group this is: Local Health Dept, Medical/Dental care facility, Early Head Start, Head Start, Michigan Readiness, Early On, etc. and a contact person's information. *See Attachment V.***

- **If you are an existing Varnish! Michigan Program participant please indicate the number of children and fluoride varnish applications you are currently serving as well as expansion program numbers.**

- **You must provide letters of support and commitment to this program from each agency you will be servicing including existing Varnish! Michigan participants. These letters must collaborate the number of children to be seen in the 12 month period and the expected number of fluoride varnish applications. They should include the dates the services are to be provided and must be signed by the Director of the agency or Health Coordinator. ***Your proposal will NOT be considered if these letters are omitted. See *Attachment VI.***

- Applicants must state their proposed procedures for providing the dental screenings and fluoride varnish on the enclosed ***Work Plan, Attachment II***, in regards to:

a. Identify who will be providing the dental screenings and fluoride varnish (Dentist, PA 161 Dental Hygienist, Dentist-Dental Assistant team, Physician, Nurse Practitioner, Physician's Assistant, Registered Nurse).

b. Define infection control procedures.

c. Describe oral screening protocol.

d. Describe fluoride varnish application protocol.

e. Develop and implement a dental education plan for infant or preschool/group staff.

f. Develop and implement a dental education plan for parents or primary caregivers.

g. Utilization of a caries risk assessment plan: (The Caries-risk Assessment Tool developed by the American Academy of Pediatric Dentistry is recommended).

h. Utilization of the MDCH Parent Consent, Survey, Screening Forms. (The Parent Consent and Screening Forms can be adapted to your own program as long as they contain required information). Samples of these forms available upon request.

i. Your plan to enter data collected into the provided MDCH spreadsheet or Access program and describes who will be accomplishing this. You must have access to WinZip and Access on your computer for transferring of this data. Sample of this spreadsheet or Access program available upon request.

j. Identify 1 or more dental care facilities that the children will be referred to for continued dental care (a dental home).

- **Every child in the infant and/or preschool group must be given the same opportunity for a dental screening and fluoride varnish application, regardless of ability to pay, Medicaid or insurance status.**
- 0-2 age children with parental permission will receive two (2) dental screenings, one at the first varnish application and one at the fourth varnish application. Two to four (2-4) fluoride varnish applications will be provided in a 12-month period.
- 3-5 age children with parental permission will receive two (2) dental screenings, one at the first fluoride varnish application and one at the second fluoride varnish application. Two (2) fluoride varnish applications will be provided in a 12-month period, (6 months apart if billing is to occur).
- **Dental health care education must be a part of the program addressed to the infant/preschool staff and the parents of these children.**
- **Any providers, clinicians and recording personnel involved in this program must attend one training session provided by MDCH to review screening protocol, varnish application, and recording information before their program begins. Dates to be announced.**
- Performance measures must be evaluated by your program according to your ***Work Plan*** on a quarterly basis. Please state the person responsible for this. ***See Attachment II .***
- Data spreadsheets, Surveys and Work Plan performance measures must be submitted to MDCH quarterly. **Data spreadsheets or an Access Program will be transmitted via WinZip and you must have these features available to you.**
- Site evaluations of the program by MDCH should be expected.

- Applicants must identify linkages to a dental care facility. Collaboration and support letters from the dental care facility showing linkages with a "dental home" must be included with your proposal. Where will the children be referred for continued care and who is responsible for follow up to this.

- The completed Funding Estimate Worksheet must be included with your final proposal. ***See Attachments III and IV.***

- **Proposals must address all requirements and specifications of this RFP.**

DIRECTIONS FOR COMPLETING THE APPLICATION

I. Cover Sheet: *Attachment I*

A. Project Title: Enter name of fluoride varnish program.

B. Amount of Request: Enter the amount requested from MDCH for reimbursement for each fluoride varnish applied.

C. Name of Applicant Organization: Enter name of the applicant organization. Enter the name and title of the person officially authorized by the applicant organization to enter into agreements (usually chief administrative officer). Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

D. Authorized Official: Enter the name of the authorized official of your agency including name, title, mailing address, telephone, fax, and e-mail address.

E. Contact Person: Enter the name and title of the contact person who will be responsible for overseeing the project. Enter the mailing address, including city, county, state and ZIP code. Enter the telephone number, fax number and e-mail address.

F. Legal Status of Organization (*check only one response*): Check only the box that applies and attach a copy of requested Internal Revenue Service materials.

G. Federal Tax Identification Number: Enter Federal Tax Identification Number (also known as Federal Employer Number) as assigned by the Internal Revenue Service.

H. Authorizing Entity: An official authorized to bind the applicant organization to its provisions must sign the original proposal in ink. Print name and enter date of signature.

II. Narrative: A narrative/description of each heading below needs to be included in each proposal along with any required attachments. See Selection Criteria on page 8 for additional information on each topic.

A. Needs Statement

B. Program Description/Work plan

C. Funding Estimate Worksheet

D. Community Involvement and Partnerships

E. Workforce

F. Program Sustainability

G. Budget Narrative, Summary and Program Budget Cost Detail Schedule ***(See Attachments B.1 and B.2) An electronic version is available upon request.***

H. Overall Quality of the Project

III. Narrative Guidelines

A. Format: Please submit in single spaced, 12 point font. For charts, graphs, footnotes and budget tables, applicants may use a different pitch or size font, not less than 10 pitch or size font. However, it is vital that when scanned and or reproduced, the charts are still clear and readable.

B. Paper Size and Margin: The application must be printed on an 8 ½" X 11" white paper. Margins must be at least one inch. Please left-align text.

C. Page Numbering: Please number all pages, beginning with the Title Page as page 1.

D. Page limit: Page limit is 10-15 pages; the Title Page, Cover Sheet, Funding Worksheet, Work Plan, Program Budget and Letters of Support are not included in the page limit

SELECTION CRITERIA

A. Needs Statement (20 points): The needs statement is a concise, descriptive statement identifying the needs to be addressed by the program.

- Applicants must determine the number of 0-5 age high risk children in their area they can reasonably provide dental screenings and fluoride varnish to in the 12-month period. Please subtract 20% for refused consent and absenteeism.
- Remember that the 0-2 age groups should receive 2-4 applications of fluoride varnish in a 12 month period and the 3-5 age group should receive 2 applications.
- How many of the children you plan on servicing are in the 0-2 age group? Will you be able to apply 4 applications of fluoride varnish in a 12 month period?
- If you are an existing Varnish! Michigan program participant that wants to expand their program, please list your current level of infrastructure, capacity and need of the expansion.
- Applicants will want to provide information as to the specific dental care needs of this target group. Why are they high risk for decay?
- Regionalize your area. Why is your area special? Describe your area compared to Michigan. Is your area designated a Health Professional Shortage Area?
- The number of dental care providers per this population in the applicant's area must be determined.
- Describe your community's water fluoridation. How many of the children you plan on servicing are in a non fluoridated area?
- Why are you requesting this grant?
- What impact will this program have on your population? For decay rates? For education purposes?
- Need for the program should be supported by local and state data.

B. Program Description/Work plan (30 points): Applicants must complete the ***Work Plan*** page that is attached by stating the fluoride varnish program's main goal, activities for the program, evaluation measures for each activity,

the time frame for each activity, and the person who is responsible for the activity. Refer to Specifications above and ***Attachment II.***

- The program goal should be a broad statement of purpose. What do you hope to accomplish from this program?
- The program's activities would be things such as, getting support and commitment letters signed from the groups you will be servicing, getting parent consent forms signed, developing an oral health education plan for the staff and parents, protocols for the screenings and varnish applications, caries risk assessment, and follow up for further dental care, etc.
- The evaluation measures for each activity would include things such as, how many support and commitment letters do you need to obtain, what percentage of parent consents do you need returned, what percentage of the children is your target for the screenings and varnish applications, how do you determine if enough parents are reached for a caries risk assessment, how will you keep track of referrals for care, etc. What kinds of outcomes are you expecting from each activity? What do you expect? How is your evaluation used to impact your program?
- The time frames should reflect approximate dates the activities will be carried out and finalized.
- The person responsible would be any individual(s) who are monitoring the activity and its outcomes. Please include all providers, supervisors and directors.
- What outcomes do you expect overall from this program?
- How will you evaluate this program overall?
- Use extra copies of the Work plan as needed. Use separate sheets for the outcome and evaluation briefs as needed.

C. Workforce (10 points): Describe the workforce for this program.

- Who will be doing what activity?
- What are their credentials?
- List the supervisor for each person
- How many hours will each staff member devote to this project?
- Is the amount of staff hours sufficient to cover the number of children expected to be seen?
- What is the experience with the 0-5 age group?
- Is a person other than a dental professional performing the oral screenings and applying the fluoride varnish?
- Include this information in your narrative and ***Work Plan.***

D. Community Involvement and Partnerships (10 points): Proposals should demonstrate a community effort through significant involvement of partners such as**:**

- Early Head Start, Head Start centers, Michigan Readiness, Early On, etc.
- Other early childhood development groups
- Local health departments
- Local public dental health care facilities
- Federally Qualified Health Centers (FQHC's)
- Local dental offices
- Community health centers
- Local dental and dental hygiene associations
- Coordination among involved agencies will also be evaluated.
- **Letters to support partnerships must be attached.**

E. Project Sustainability (10 points): The proposal must demonstrate the capacity to sustain services beyond the terms of the contract. Applicants must show how they can continue a fluoride varnish program to 0-5 age children in their area without MDCH funds.

- Will Medicaid and other insurances be billed?
- Are other funding sources approachable such as, community organizations, dental/dental hygiene components?
- Other grants?

F. Funding Estimate Worksheet (10 points): Applicants must complete the ***Funding Estimate Worksheet*** page that is attached by estimating the number of 0-5 age children that could reasonably be seen in a 12-month period minus 20% for refused consents and absenteeism. (See sample estimate worksheet ***Attachment III***). Estimate the number of fluoride varnishes to be provided by multiplying the number of 0-2 age children by two to four (2-4) and the number of 3-5 age children by two (2). Estimate the total number of varnish applications to be provided in the 12- month period for this program. Determine the estimated reimbursement generated from your fluoride varnish program by multiplying the number of fluoride varnish applications by $15.00 for the MDCH grant. You may wish to calculate any Medicaid or other reimbursement, subtract estimated expenses, and then give a final estimated reimbursement total generated from your program. ***(See Attachments III and IV)***

G. Budget Narrative, Summary and Program Cost Detail Schedule (20 points): Determine all funds necessary to support the proposed program. See budget forms and instructions- Attachments B.1 and B.2.

- Complete and attach the state budget forms, DCH 0385 and DCH 0386. Electronic versions available upon request.
- Include a budget narrative. Descriptions should correspond with information submitted on DCH 0385 and DCH 0386 forms.
- Identify the amount of funds requested and any cost sharing among partners.
- Identify the program's fiduciary.
- Include all revenues necessary to support the proposed program.
- Funds must be used for staff, travel, and supplies for the fluoride varnish program.
- Funds can only be used to start up new fluoride varnish programs or expand existing programs.
- Include the ***Funding Estimate Worksheet. Attachment IV.***

H. Overall Quality of the Proposal (25 points): Proposals must demonstrate an effective, efficient, and sustainable fluoride varnish program to 0-5 age children in Michigan that will lead to reduced caries in this population.

- The proposal includes a list of infant and/or preschool groups to be serviced and the number of children to be seen minus 20% for refused consents and absenteeism. 0-2 age children must be indicated with the number of fluoride applications expected to be delivered. ***Attachment V.***
- Please include sites and number of children being seen as part of an existing fluoride varnish program. If appropriate, list the number of new children to be added to an existing program.
- Letters of support and commitment to this program from each agency listed are included and signed by the Director or Health Coordinator. The number of children to be seen and the number of expected fluoride varnish applications is indicated on these support letters.
- A needs narrative is included describing each point as outlined in the Selection Criteria above.
- A Work Plan is included identifying each activity as outlined in the Specifications. An evaluation measure for each activity, the time frame for each activity, and the person responsible for each activity is included. ***Attachment II.***
- References as to how and when evaluation of the ***Work Plan*** will be made are included.
- Community involvement and partnerships are described. Letters of support are attached.
- The Funding Estimate Worksheet is included in your proposal.

- The Workforce is described in your narrative and ***Work Plan***.
- The proposal demonstrates program sustainability.
- A budget narrative and summary is included with the state budget forms DCH 0385 and DCH 0386.
- The proposal includes the application cover sheet and all requested attachments.

Total: 135 points

Priority Bonus Points (20 points each)

- **Areas with no or limited community water fluoridation**- Status of community water fluoridation is clearly described for each area of service. Refer to http://apps.nccd.cdc.gov/MWF/Index.asp for community water fluoridation information.

- **Areas are designated HPSA** – The areas to be serviced are described as a Health Professional Shortage Area. Refer to http://www.michigan.gov/mdch/0,1607,7-132-2945_47514---,00.html for a list of HPSA areas in Michigan.

- **Your program is directly related to a local dental public health department or FQHC-** This is to encourage a dental home for these children.

- **New and expanding fluoride varnish programs-** This is a new program through MDCH looking for funds to get a fluoride varnish initiated in your area. This could also be an existing Varnish! Michigan program looking to expand your number of 0-5 age children seen. Please indicate the number of children and varnish applications you are expecting to expand as well as existing program numbers.

- **Programs include 0-2 age children** – These young age children are clearly indicated as a main focus of this program and four (4) applications of fluoride varnish are planned for each.

- **Programs include a plan for oral health education to staff and parents**- There is a definite oral health education plan outlined in the proposal to reach staff and parents.

Grand Total: 255 points

Attachment I

VARNISH! MICHIGAN 2008-2009 GRANT APPLICATION FOR BIRTH-5 AGE CHILDREN IN MICHIGAN

Cover Sheet

(type or print)

Project Title: _____

Amount of Request: $ _____ *Attach Funding Estimate Worksheet*

Name of Applicant Organization: _____

Authorized Official: _____

Title: _____ _____

Mailing Address: _____

City:_____County:_____State:_____ Zip:_____

Telephone: _(____)_____ Fax:_(____)_____

E-mail Address:_____

Contact Person: _____

Title: _____ _____

Mailing Address: _____

City: _____County:_____ State:_____ Zip:_____

Telephone: _(___)_____ Fax:_(___)_____

E-mail Address: _____

Legal Status of Organization (*check only one response*):

{ } Public Agency/Unit of Government

{ } Private, Nonprofit Entity *(attach copy of IRS 501(C)(3) or other legal document verifying status)*

{ } Other: Describe_____

Federal Tax ID Number: _____

Authorizing Entity: I hereby affirm my authority and responsibility for the use of all staff, equipment, supplies and educational training described in this application.

_____ _____ _____

Authorized Individual (*Signature)* Printed Name

Date:_____

Attachment II
Varnish! Michigan
Work Plan

State the overall goal of the program. List the activities, evaluation measures, time frames, and person responsible in the appropriate columns. (Please make duplicate copies of this page).

Project Goal:_____

_____

Activity	Evaluation Measure	Time Frame	Person Responsible

What outcomes do you expect from this program?

How will you evaluate this program overall?

(Please use separate sheet for these answers.)

Attachment III (Example)
Varnish! Michigan

Example Funding Estimate Worksheet

(This form is an example of Attachment IV.)

This MDCH grant is reimbursed at **$15.00** per application of fluoride varnish per child during a 12-month period. Four varnish applications should be applied quarterly to high risk infants/children ages 0-2. Two varnish applications should be applied every 6 months to high risk children ages 3-5.

Total Estimated Number of 0-2 age Children:	30
Subtract 20% for refused consents and absenteeism:	- 6
Total Estimated 0-2 Age Children to be Seen:	**24**
Multiplied by 2,3,or 4 Fluoride Varnish Applications Each Child Receives:	X **4**
Total Estimated 0-2 age children Fluoride Varnish Applications:	**= 96 (A)**

Total Estimated Number of 3-5 age Children:	200
Subtract 20% for refused consents and absenteeism:	- 40
Total Estimated 3-5 Age Children to be Seen:	**160**
Multiplied by 2 Fluoride Varnish Applications Each Child Receives:	X **2**
Total Estimated 3-5 age Fluoride Varnish Applications:	**= 320 (B)**

Estimated Fluoride Varnish Applications for 0-2 age Children:	**96** (A from above)
Estimated Fluoride Varnish Applications for 3-5 age Children:	+ **320** (B from above**)**
Total Estimated Fluoride Varnish Applications:	**= 416** (C)

Number of Fluoride Varnish Applications:	**416** (C from above)
MDCH Grant Reimbursement per Fluoride Varnish Application:	X **$15.00**
TOTAL ESTIMATED MDCH GRANT REIMBURSMENT:	**$ 6240.00 (D)**

Optional: You can determine the estimated reimbursement generated from your fluoride varnish program.

Total Estimated MDCH Grant reimbursement:	$ _____ (D from above)
Total Medicaid reimbursement based on current billable reimbursement fee for your clinic/agency	$ _____ (E)
Other Estimated Billable reimbursement *(please specify)*_____ (i.e Grants, private insurance, donations, etc.)	$ _____ (F)
Estimated Income:	$ _____ **(D+E+F)**
SUBTRACT ESTIMATED EXPENSES: (i.e. personnel, gloves, varnish, forms, etc.)	$ _____
Total Estimated Net :	*$*_____

* If a Medicaid provider, please reference the Medicaid Manual for additional specifics on screenings and prophylaxis prior to a fluoride varnish application.

Attachment IV
Varnish! Michigan

Funding Estimate Worksheet

(This form MUST be attached to the final grant proposal.)

This MDCH grant is reimbursed at **$15.00** per application of fluoride varnish per child during a 12-month period. Four varnish applications should be applied quarterly to high risk infants/children ages 0-2. Two varnish applications should be applied every 6 months to high risk children ages 3-5.

Estimated Number of 0-2 Age Children : _____

Subtract 20% for Refused Consents and Absenteeism: _____

Total Estimated 0-2 Age Children to be Seen: _____

Multiplied By 2, 3, or 4 Fluoride Varnish Applications Each Child Receives: X _____

Total Estimated 0-2 Age Children Fluoride Varnish Applications: _____ **(A)**

Estimated Number of 3-5 Age Children: _____

Subtract 20% for Refused Consents And Absenteeism: _____

Total Estimated 3-5 Age Children to be Seen: _____

Multiplied By 2 Fluoride Varnish Applications Each Child Receives: X **2**

Total Estimated 3-5 Age Fluoride Varnish Applications: _____ **(B)**

Estimated Fluoride Varnish Applications For 0-2 Age Children: _____(A From Above)

Estimated Fluoride Varnish Applications For 3-5 Age Children: +_____(B From Above**)**

Total Estimated Fluoride Varnish Applications: _____**(C)**

Number Of Fluoride Varnish Applications: _____ (C From Above)

MDCH Grant Reimbursement per Fluoride Varnish Application: X **$15.00**

TOTAL ESTIMATED MDCH GRANT REIMBURSMENT: **$** _____ **(D)**

Optional: You Can Determine the Estimated Reimbursement Generated From Your Fluoride Varnish Program.

Total Estimated MDCH Grant Reimbursement: **$** _____**(**D From Above)

Total Medicaid Reimbursement Based On Current Billable Reimbursement Fee for Your Clinic/Agency **$** _____**(**E)

Other Estimated Billable Reimbursement *(Please Specify)*_____ **$** _____(F)
(I.E Grants, Private Insurance, Donations, Etc.)

Estimated Income: **$** _____**(D+E+F)**

SUBTRACT ESTIMATED EXPENSES*:* **$**_____
(i.e. Personnel, Gloves, Varnish, Forms, Etc.)

Total Estimated Net : ***$***_____

_____

* If a Medicaid provider, please reference the Medicaid Manual for additional specifics on screenings and prophylaxis prior to a fluoride varnish application.

Attachment V
List of Infant and Preschool Groups
Varnish! Michigan 2008-2009

Please make a list of any infant and/or preschool group you will be working with to provide the dental screening/fluoride varnish program. Please indicate which age group, 0-2 or 3-5, and what type of program, (Head Start, Michigan Readiness, Health Department etc.). (You may duplicate this page).

Name of Center:	Address:	County:	# of Children:	Age Group:	Program:
1._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

2._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

3._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

4._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

5._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

6._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

7._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

8._____	_____	_____	_____	_____	_____

Contact Information: Name:_____Phone:_____e-mail:_____

# of 0-2 age children:_____ minus 20%= Total:_____ Number of fluoride varnish applications:_____ (in 12 month period)

# of 3-5 age children:_____ minus 20%= Total:_____ Number of fluoride varnish applications:_____ (in 12 month period)

Attachment VI
Support and Commitment Letter
For Varnish! Michigan
2008-2009

We, _____support and are committed to the services
(Agency)

of_____ for providing dental screenings and applying
(Provider name)
fluoride varnish to the children of our center, dental or medical care facility through the Michigan Department of Community Health's Varnish! Michigan Program from October 1, 2008 through September 30, 2009.

The program has been explained to us in detail and we agree to follow the recommended requirements of the program. The following is the list of sites to be served, the type of program, the number of children in each age bracket, the number of fluoride varnishes to be applied in the 12 month period, and the dates the services are to be carried out. (Please use additional pages as needed.)

Site:	**Type of Program:**	**# of Children:** **0-2** **3-5**	**# of Fl V Appli:** **0-2** **3-5**	**Dates of Service:**

(This form must be signed by the Agency Director or Health Coordinator)

Signed: _____ Title: _____

Address: _____ Phone: _____

E-Mail:_____

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM			DATE PREPARED	Page	Of
CONTRACTOR NAME			BUDGET PERIOD From To:		
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT ▶	AMENDMENT #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		

EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	$0	$0	$0	$0
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

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DCH-0385(E) (Rev 2-07) (W) Previous Edition Obsolete.

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL SCHEDULE

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page of

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	BUDGET AGREEMENT **ORIGINAL** **AMENDMENT**		**AMENDMENT #**

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
			$0
			$0
			$0
			$0
			$0
			$0
			$0
	1. TOTAL SALARIES & WAGES:	0	$ 0

2. FRINGE BENEFITS (Specify)

FICA LIFE INS. DENTAL INS. COMPOSITE RATE
UNEMPLOY INS. VISION INS WORK COMP. AMOUNT 0.00%
RETIREMENT HEARING INS.
HOSPITAL INS. OTHER (specify) _____

2. TOTAL FRINGE BENEFITS: $0

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $0

4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $0

5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name Address Amount

5. TOTAL CONTRACTUAL: $0

6. EQUIPMENT (Specify items)

6. TOTAL EQUIPMENT: $0

7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

7. TOTAL OTHER: $0

8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	**8. TOTAL DIRECT EXPENDITURES:**	$ 0
9. INDIRECT COST CALCULATIONS	**Rate #1: Base $0 X Rate 0.0000 % Total**	$ 0
	Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
	9. TOTAL INDIRECT EXPENDITURES:	$ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)		$ 0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

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